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Original Article

Countertransference and therapeutic alliance in the early stage of adult psychodynamic psychotherapy

Contratransferência e aliança terapêutica no início da psicoterapia psicodinâmica de adultos

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Abstract

Objectives: The primary objective of this study was to assess the relationship between countertransference (CT) and therapeutic alliance (TA) during the early stages of psychodynamic psychotherapy. A secondary objective is to assess associations between CT and variables related to therapist and patient and between CT and other patient variables investigated, which were defense mechanisms, symptomology and functionality.

Methodology: This was a cross-sectional study that enrolled 30 patients treated by 17 different therapists at the psychotherapy clinics of two psychiatry centers. Assessments of each patient-therapist pair were conducted between their fourth and 10th sessions.

Results: The CT distance domain exhibited a moderate negative correlation with TA, particularly its sub-dimension representing the patient's capacity for work in therapy. Moderate positive correlations were observed between CT distance and the splitting defense mechanism and between CT closeness and suppression defenses, in addition to moderate negative correlation between CT indifference and the fantasy defense mechanism. Another finding was higher scores for CT indifference in association with socioeconomic classes D and E.

Conclusions: The quality of CT may provide a source of information about TA. A high degree of CT distance represents a low level of TA, particularly with relation to the patient's working capacity, although presence of the splitting defense mechanism can affect CT, to the extent that it constitutes a confounding variable. The concept of CT is useful to psychotherapists, providing a source of information about the patient's internal world and about certain elements of therapy, such as the quality of TA, which is important for good treatment results.

Keywords: Psychotherapy, psychoanalytic therapy, psychoanalysis, countertransference, therapeutic alliance.

Resumo

Objetivos: O objetivo principal desta pesquisa foi avaliar a relação entre a contratransferência (CT) e a aliança terapêutica (AT) no início da psicoterapia psicodinâmica. O objetivo secundário é avaliar a associação da CT com as variáveis da dupla e da CT com as demais variáveis do paciente avaliadas, que foram os mecanismos de defesa, sintomatologia e funcionalidade.

Metodologia: Trata-se de um estudo transversal com 30 pacientes do ambulatório de psicoterapia de dois serviços de psiquiatria, atendidos por 17 terapeutas. As avaliações ocorreram entre quarto e décimo encontros da dupla.

Resultados: A dimensão da CT distância apresentou correlação negativa moderada com a AT, especialmente sua dimensão que representa a capacidade de trabalho em terapia do paciente. Foram verificadas correlações moderadas positivas entre CT distância e cisão e entre CT proximidade e supressão, além da correlação moderada negativa da CT indiferença com fantasia. Outro dado encontrado foi a presença de maiores níveis da CT indiferença diante de pacientes da classe socioeconômica D e E.

Conclusões: A qualidade da CT pode servir de fonte de informações sobre a AT. A presença de alta CT que indica distância está relacionada a baixa AT, sobretudo em relação a capacidade de trabalho do paciente, ainda que a presença de cisão pode influenciar a CT, de forma que representa uma variável de confusão. A CT é um conceito útil ao psicoterapeuta, servindo como fonte de informações sobre o mundo interno do paciente e sobre elementos da psicoterapia, como a qualidade da AT, importante para os bons resultados dos tratamentos.

Descritores: Psicoterapia, psicoterapia psicanalítica, psicanálise, contratransferência, aliança terapêutica.

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Introduction

Countertransference (CT) is an important element of psychotherapy and understanding it is a useful tool for the psychotherapist's work. It was mentioned for the first time by Freud in 1910,[1] who described it as a result of the patient's transference on the therapist's unconscious conflicts, and again in 1912,[2] when he stated that CT could pose a threat to treatment and should be avoided. His scientific contributions on the subject were scant, in comparison with other concepts such as transference or resistance, but his direct contribution was important to defining clear limits, from the technical point of view, to a concept that was not very well understood. Furthermore, during his time there had been a series of scandals involving psychoanalysts overstepping the limits and he had proposed that the subject should be discussed via correspondence.[3]

During the early years of psychoanalysis, the CT model known as the classic view predominated, by which CT was considered an obstacle to treatment and was explored little.[4] From the end of the 1940s onwards, the subject began to receive greater attention, initially in the work of three authors. Winnicott[5] described the rage provoked by psychotic patients. Heimann[6] described CT as a source of information about the patient's internal world. Racker[7,8] conducted more in-depth work on the subject and classified CT as concordant or complementary and introduced terms such as CT neurosis, concluding that it is both an obstacle and a tool. These authors developed a model known as the totalistic model, in which CT comprises the totality of the therapist's emotions with relation to the patient.[4]

Over more recent years, CT has gained a privileged position in the theory and technique of psychotherapy and psychoanalysis, evolving from the concept of a mere response to the patient's transference into a complex creation in conjunction between the therapist-patient dyad.[9] Although it is extensively discussed within the context of psychoanalysis and of modern relational theory, there is increasing recognition of its importance in the therapeutic relationships of other psychotherapy techniques, such as cognitive-behavioral therapy (CBT).[10] Over recent decades, understanding of countertransference has been important to the evolution of other concepts, such as projective identification, enactment, role-responsiveness, analytic field, intersubjectivity, analytic third, session personalities and possible worlds.[4,11,12]

The term therapeutic alliance (TA) designates the capacity to establish a working relationship between therapist and patient, in opposition to regressive and resistive transferential reactions. This concept has its origins in psychoanalysis, but it is present in all doctor-patient relationships and not only in psychotherapy.[13] It was indirectly described by Freud at different points, such as in 1912, when he mentioned the collaborative relationship between analyst and patient.[14] However, in the form in which we know it today, the term can be attributed to Zetzel in 1956.[15]

The TA is also recognized as essential in CBT, in which one of the primary objectives of psychotherapy is the establishment of a solid relationship, primarily constructed through common interests, empathy, trust and honesty.[16] This is currently one of the most studied concepts in psychotherapy and it has a significant relationship with the outcome of treatment.[17-20]

To date, few studies have investigated the relationship between the characteristics of CT and TA. One recent systematic review identified three studies with this objective.[21] The first was a study of cocaine addicts, which identified a moderately strong correlation between a positive CT (related to pleasant feelings, such as trust and curiosity) and TA in the therapist version, but demonstrated a weak correlation with TA in the patient version.[22] The second study assessed CT among psychology therapists on postgraduate courses and patients who were psychology students, identifying negative correlations between TA and both positive and negative CT (the latter relates to unpleasant emotions such as rage), i.e., extreme CT emotions are related to a weaker TA.[23] The third of these studies investigated patients with a range of diagnoses who were undergoing manualized psychodynamic psychotherapy and found a positive correlation between TA and positive CT.[24]

According to Gabbard, research shows that TA is a factor that influences the process and the result of psychotherapies following a diverse range of approaches and the quality of TA during the initial phase of treatment is the factor that best predicts the results of that treatment.[25] In turn, CT, is a wide concept that can be studied and understood from a variety of perspectives. The aspect of CT that is investigated in this study involves the feelings triggered in the therapist during the session.

The primary objective of this study is to evaluate correlations between TA and CT during the initial phases of psychodynamic psychotherapy, identifying whether the therapists' feelings allow for inferences about the characteristics of the TA. Secondary objectives are to evaluate the relationship between CT and patients' defense mechanisms, symptomology, level of functioning and socioeconomic level, in addition to certain demographic and clinical data.

Methodology

This is a cross-sectional study conducted at the psychodynamic psychotherapy clinics at two universities in Rio Grande do Sul, Brazil: the Hospital de Clínicas de Porto Alegre (HCPA), affiliated to the Universidade Federal do Rio Grande do Sul (UFRGS) and the Universidade Federal de Pelotas (UFPel) Mental Health Department. The study is registered on the Plataforma Brasil human research database and has been approved by the HCPA Ethics Committee (ethics assessment certificate number: 25992213.8.1001.5327).

Assessments were conducted between March and June of 2014. At three different points during the study the researchers asked therapists whether they were seeing patients who met the following criteria: over 18 years of age, psychodynamic psychotherapy contract agreed upon, and having attended more than three and less than 11 sessions. The fourth session was chosen as an initial stage of psychotherapy, soon after the first assessment phase, which in this type of therapy tends to take place after two or three sessions,[26] and the tenth session was chosen as an arbitrary cutoff.

All therapy was provided through the Brazilian National Health Service (SUS - Sistema Único de Saúde). The patients were members of the community who had been referred to the clinics for assessment. The therapists were psychiatry residents in their second, third or fourth years. As part of their training their residency programs include individual supervision with scripted interviews, collective supervision, and theoretical and clinical seminars. The duration of therapy varies, but generally coincides with the period during which the resident is assigned to the clinic. Session frequency was once or twice a week and duration was 50 minutes.

All participants were sent free and informed consent forms via email. Those who agreed to take part were sent links to questionnaires created using Surveymonkey, which is a server specialized in Internet-based surveys. Therapists were requested to complete their questionnaires within 24 hours of receipt, while patients were asked to complete their questionnaires within 7 days. If these deadlines were not met, participants were excluded from the study.

Instruments administered to the therapists

Assessment of Countertransference Scale (ACTS)

This scale assesses emotional responses at the start, midpoint and end of a specific therapy session. The scale comprises 23 emotions and there are four response options ranging from 0 to 3, where 0 signifies absence and 3 signifies strong presence of emotion. These emotions each belong to one of three domains that indicate the types of feelings linking the therapist to the patient in the session assessed: closeness, distance and indifference. The closeness domain comprises curiosity, interest, sympathy, solidarity, affection, wish to help, happiness, sadness, pity and attraction. The distance domain covers discomfort, mistrust, boredom, rejection, despair, reproach, accusation, irritation, fear and hostility. The indifference domain includes disinterest, distance and immobility. The scale was developed as part of a qualitative study[27] and to date its psychometric properties have been assessed in a study of trauma victims, in which its dimensions exhibited internal consistency scores (Cronbach's α) ranging from 0.72 to 0.88.[28]

Global Assessment of Functioning (GAF)

The assessment system from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) provides a general description of an individual's level of functioning and the intensity of their symptoms on a scale from 1 to 100, where 1 represents the greatest severity of symptoms and worse functioning, while 100 represents cases with above average functioning in some areas and an absence of incapacitating symptoms.[29]

Instruments administered to the patients

California Psychotherapy Alliance Scale, Patient Version (CALPAS-P)

This scale assesses the therapeutic alliance in patient and therapist versions over 24 items, on a scale ranging from 1 to 7 (from "not at all" to "very much so"). It provides an overall score that is made up of the sum of four dimensions of alliance: patient commitment (PC), patient working capacity (PWC), therapist understanding and involvement (TUI) and working strategy consensus (WSC).[30] The four sub-scales have Cronbach's α varying from 0.43 to 0.73 and the overall scale score is 0.83.[31] The patient version has been translated into Portuguese and its reliability has been tested for the Brazilian population, resulting in sub-dimension Cronbach's α varying from 0.56 to 0.84 and a total scale score of 0.90.[32]

Symptom Checklist (SCL-90-R)

This inventory assesses psychopathological symptoms. Each of the 90 items has responses on a scale from 0 to 4, ranging from "not at all" to "extremely". It assesses nine dimensions of symptoms, as follows: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism. It has three indices: the Global Severity

Index (GSI), which measures the level of symptoms, the Positive Symptom Total (PST), which lists the number of types of symptoms present, and the Positive Symptom Distress Index (PSDI), which indicates the intensity of symptoms and is derived by dividing GSI by PST.[33] The scale has been adapted for the Brazilian population and this version has Cronbach's α varying from 0.73 to 0.88.[34]

Defense Style Questionnaire (DSQ-40)

The scale contains 40 items scored from 1 to 9 (disagree completely to agree completely) that assess 20 psychological defense strategies: anticipation, suppression, humor, sublimation, idealization, pseudo-altruism, reactive formation, undoing, projection, denial, splitting, acting out, devaluation, dissociation, somatization, displacement, rationalization, isolation, fantasy and aggression. These in turn are grouped into three defense categories: mature, neurotic and immature.[35] This scale has been adapted for the Brazilian population, with Cronbach's α varying from 0.52 to 0.77.[36]

ABIPEME socioeconomic criteria

This socioeconomic classification was developed by the Brazilian Association of Market Research Institutes (ABIPEME - Associação Brasileira de Institutos de Pesquisa de Mercado) to divide the population into categories according to their patterns of or potential for consumption.[37] Class A indicates the highest incomes and E the lowest.

The patients' primary diagnoses were defined by the therapist according to the criteria contained in the International Classification of Diseases (ICD-10), but no instrument was used for this purpose.

Statistical analysis

The number of therapist-patient dyads enrolled was 30, which offered the possibility of detecting correlation coefficients of 0.5, with 80% power and a two-tailed significance level ($p = 0.05$). Data distributions were evaluated using the Shapiro-Wilk method. Differences between the three CT domains and the three data collection times in each session (start, midpoint and end) were assessed using the Friedman test. Correlations between continuous variables were calculated using the Pearson (r) and Spearman (ρ) methods. Associations between CT and dichotomous categorical variables were evaluated using the independent *t* test, or the Mann-Whitney test, for nonparametric variables. Comparisons between three or more groups were conducted using one-way analysis of variance (ANOVA), preceded by the Levene test to verify homogeneity of variance. The Tukey test was applied post hoc to identify differences between groups. Comparisons between three or more groups of nonparametric variables were made using the Kruskal-Wallis test.

Results

A total of 30 patients and 17 therapists took part in the study. Table 1 lists some of the demographic characteristics of the sample.

Table 1 - Demographic characteristics of the sample

Therapists (17)	
Patients per therapist (range)	1.7 (1-4)
Age	29.17±5.7
Female	8 (47.05)
Year of residency	
2nd	8 (47.1)
3rd	7 (41.2)
4th	2 (11.7)
Patients (30)	
Female	23 (76.7)
Age	33.6±2.3
GAF	68.9±10.7
On medication	22 (73.3)
Frequency of sessions	
1 per week	24 (80)
2 per week	6 (20)
Marital status	
Single	20 (66.7)
Married	3 (10)
Stable relationship	5 (16.7)
Separated	2 (6.7)
Educational level	
Graduated higher education	5 (16.7)
Started higher education	11 (36.7)
Graduated secondary education	4 (13.3)
Started secondary education	5 (16.7)
Graduated primary education	2 (6.7)
Started primary education	3 (10)
Socioeconomic class	
B	8 (26.7)
C	18 (60)
D	3 (10)
E	1 (3.3)
Primary psychiatric diagnosis*	
Mood disorder	24 (80)
Anxiety disorder	4 (13.3)
Personality disorder	2 (6.7)

Data presented as n (%) or mean ± standard deviation, unless otherwise stated.
GAF = Global Assessment of Functioning.
* International Classification of Diseases (ICD-10).

Comparisons between the three CT domains showed that the closeness domain predominated (mean rank [mr] = 2.97) over distance (mr = 1.48) and indifference (mr = 1.65); (chi-square = 34.094, degrees of freedom [df] = 2, p = 0.0001). With relation to differences of intensity within each domain across the three session times (start, midpoint and end), differences were detected in closeness between the start (mr = 2.08), midpoint (mr = 2.33) and end of sessions (mr = 1.58); (chi-square = 9.545, df = 2, p = 0,08). There was a strong correlation between indifference and distance (r = 0.71 and ρ = 0.76, both p = 0.001), neither of which were correlated with closeness.

Correlations between ACTS and CALPAS-P are shown in Table 2. It was observed that there were moderate negative correlations between CT distance and total CALPAS-P score (ρ = -0.38, p = 0.41) and the CALPAS-P PWC domain (ρ = -0.38, p = 0.41).

Table 3 lists correlations between ACTS scores and other continuous clinical variables. No significant correlations were detected between ACTS and age of therapist, age of patient or GAF or with the symptom domains or SCL-90-R indices. Moderate and significant correlations were observed between ACTS and some of the defense mechanisms assessed by the DSQ-40, as follows: closeness correlated with suppression (ρ = 0.47), distance correlated with splitting (ρ = 0.39) and indifference correlated with fantasy (ρ = -041).

Table 4 lists the results of comparisons between the ACTS and the other categorical variables. It was found that scores for the closeness domain were higher among female therapists than among male therapists. Closeness scores were also higher in cases in which the patient was not taking medication. In two analyses that involved comparisons of variables with more than three categories it was necessary to create clusters to make it possible to conduct tests.

Table 2 - Correlations between ACTS and CALPAS-P

ACTS	Closeness	Distance	Indifference
CALPAS-P			
Total	0.06*	-0.38†‡	-0.19†
PC	0.08*	-0.31†	-0.25†
PWC	0.03*	-0.38†‡	-0.15†
TUI	0.06†	0.01†	0.12†
WSC	0.07†	-0.21†	-0.18†

CALPAS-P = California Psychotherapy Alliance Scale, patient version; ACTS = Assessment of Countertransference Scale; PC = Patient Commitment; PWC = Patient Working Capacity Scale; TUI = Therapist Understanding and Involvement; WSC = Working Strategy Consensus Scale.
* Pearson's r; † Spearman's ρ; ‡ $p < 0.05$.

Table 3 - Correlations between ACTS and demographic variables, GAF, DSQ-40 and SCL-90

ACTS	Closeness	Distance*	Indifference*
Age of patient	-0.21*	0.33	0.26
Age of therapist	0.17*	0.22	0.06
GAF	0.12†	-0.31	-0.12
DSQ-40			
Mature	0.24†	-0.21	0.02
Neurotic	-0.10†	-0.05	0.11
Immature	-0.22†	0.01	0.19
Anticipation	0.01†	-0.19	-0.08
Suppression	0.47 *‡	-0.78	0.15
Humor	0.03*	-0.23	-0.20
Sublimation	0.149†	0.23	0.32
Idealization	-0.20†	0.17	0.18
Pseudo-altruism	-0.08*	0.06	0.22
Reactive formation	0.06†	-0.12	0.01
Undoing	0.06*	-0.24	-0.23
Projection	-0.13*	0.17	0.17
Denial	0.10*	-0.02	-0.05
Splitting	-0.19†	0.39§	0.31
Acting out	-0.09*	-0.03	0.19
Devaluation	-0.05†	-0.09	-0.36
Dissociation	0.05*	0.01	0.13
Somatization	-0.09*	-0.02	0.17
Displacement	-0.06†	-0.01	-0.02
Rationalization	-0.17*	0.06	0.02
Isolation	-0.17†	-0.03	0.06
Fantasy	-0.14†	-0.34	-0.41§
Aggression	-0.07*	-0.10	0.08
SCL-90-R			
GSI	-0.25†	0.04	-0.01
PST	-0.15*	0.11	-0.01
PSDI	-0.30†	-0.17	-0.10
Somatization	-0.34†	0.14	0.08
Obsessive-compulsive	-0.22†	0.02	-0.02
Interpersonal sensitivity	-0.25†	-0.11	-0.16
Depression	-0.27†	0.03	-0.01
Anxiety	-0.20†	-0.06	-0.10
Hostility	-0.18†	0.02	0.06
Phobic anxiety	-0.10†	0.14	0.01
Paranoid ideation	-0.16†	0.02	-0.11
Psychoticism	-0.13†	-0.12	-0.13

GAF = Global Assessment of Functioning; DSQ-40 = Defensive Style Questionnaire-40; ACTS = Assessment of Countertransference Scale; PSDI = Positive Symptom Distress Index; GSI = Global Severity Index; SCL-90 = Symptom Checklist-90; PST = Positive Symptom Total.
* Spearman's ρ; † Pearson's r; ‡ $p < 0.05$; § $p < 0.01$.

For the purposes of analysis, primary diagnoses were classified into three clusters: mood disorders, anxiety disorders and personality disorders. Differences were detected between diagnoses for the CT closeness domain.

The post-hoc test indicated that closeness scores were greater in the personality disorders cluster ($F_{2.27} = 3.92$, $p = 0.032$) than in the affective disorders and anxiety disorders clusters.

Socioeconomic classification was analyzed as class B, class C and a cluster formed by combining classes D and E. The results showed that indifference scores were greater in the cluster formed from classes D and E, followed by class C, while class B exhibited the lowest indifference scores. No associations were detected between patients` sex, marital status, educational level, or with frequency of sessions.

Table 4 - Relationships between ACTS scores and demographic data, clinical data, initial diagnosis and social class

ACTS	Closeness	Distance	Indifference
Sex of therapist			
Male	1.43 (0.43)*†	16.23‡	15.70‡
Female	1.78 (0.34)	14.77	15.30
Year of residence			
2nd	1.67 (0.31)§	12.79‖	14.12‖
3rd	1.52 (0.51)	19.50	17.90
4th	1.54 (0.72)	17.50	15.33
Sex of patient			
Male	1.76 (0.29)*	16.23‡	15.70‡
Female	1.55 (0.44)	14.77	15.30
Number of sessions per week			
One	1.59 (0.41)*	15.50‡	14.65‡
Two	1.64 (0.47)	15.50	18.92
Taking medication			
Yes	1.49 (0.34)*†	17.39‡	16.55‡
No	1.92 (0.45)	10.30	12.62
Primary diagnoses			
Mood disorders	1.57 (0.39)§†	15.90‖	15.10‖
Anxiety disorders	1.44 (0.34)	11.88	14.75
Personality disorders	2.31 (0.11)	17.75	21.75
Socioeconomic class			
B	1.46 (0.34)§	10.56‖	8.31†‖
C	1.70 (0.43)	16.89	17.36
D and E	1.45 (0.44)	19.12	21.50
Marital status			
Single	1.58 (0.46)§	15.72‖	15.22‖
Married	1.85 (0.33)	10.17	17.50
Stable relationship	1.66 (0.22)	14.40	14.30
Separated	1.28 (0.35)	24.00	18.50
Educational level			
Graduated higher education	1.57 (0.56)§	12.50‖	15.80‖
Started higher education	1.59 (0.44)	17.95	18.14
Graduated secondary education	1.43 (0.29)	11.12	9.25
Started secondary education	1.71 (0.40)	15.00	16.40
Graduated primary education	2.05 (0.15)	6.75	9.75
Started primary education	1.46 (0.37)	24.00	16.00

* Independent *t* test, Mean (standard deviation); † $p < 0.05$; ‡ Mann-Whitney, mean rank; § one-way analysis of variance (ANOVA), Mean (standard deviation); ‖ Kruskal-Wallis, mean rank.
ACTS = Assessment of Countertransference Scale.

Discussion

An inverse relationship was detected between the CT distance domain and the TA experienced by the patients, especially with the TA domain that represents the patients' commitment to treatment, during the initial phase of psychotherapy. In psychotherapy practice, these results indicate that emotions related to distance on the part of the therapist may indicate a low TA. However, a high CT score for distance can also be provoked by the splitting defense mechanism and so this constitutes a confounding factor that should be considered.

Cross-sectional research is not an adequate model for attributing relationships of cause and effect and so it is uncertain whether the high scores for CT distance, which covers feelings such as discomfort, mistrust, boredom or despair, are provoked by a problem with the TA or are causing a problem with the TA.

This main finding is in tune with results in the literature, bearing in mind that instruments for assessment of CT tend to separate two groups of CT: positive and negative, as explained in the introduction. CT closeness is equivalent to positive CT, while the CT distance and indifference domains are equivalent to negative CT. Three studies similar to this one were found in the literature and they reported significant negative correlations with $r = -0.36$,[22] $r = -0.34$ to -0.58[23] and $r = -0.4$,[24] which are similar to the $\rho = -0.38$ found in this study. In other words, all of these studies identified negative relationships between negative CT and TA. In contrast, a significant negative correlation was not detected between CT indifference scores and TA in the present study. It is possible that such a result would have emerged if the sample had been larger. Additionally, no significant positive correlation was observed between positive CT and TA, in contrast with two of the three studies mentioned above ($r = 0.47$[22] and $r = 0.23$ to 0.31[24]). Analysis of the results in Table 2 reveals that the correlation coefficients do not even indicate a trend towards correlation between TA and CT closeness. Since one of the three other studies of this subject also reported a similar finding,[23] it remains uncertain whether the correlation between TA and positive CT is less striking, or whether there are other differences in sampling or assessment methods.

The analyses of relationships between CT and the secondary variables produced some statistically significant results. Considering that the principal analyses conducted in this study were evaluations of correlations, the most important secondary findings are related to defense mechanisms. Since these are characteristics of the patients themselves, it is reasonable to suppose that the defense mechanisms provoked the differences between CT types rather than the reverse. None of the other continuous variables investigated, including the symptoms categories and the degrees of severity of patients' conditions, exhibited any type of significant result in relation to CT.

The most important secondary finding was the negative relationship between splitting and CT distance, which was mentioned above as being directly related to the study's primary finding. Splitting is an immature defense mechanism in which a patient exhibits a tendency to separate aspects of the world into either entirely good or entirely bad and it is typically seen in more regressive patients.

Another finding related to defense mechanisms relates to suppression, which is a mature defense mechanism that consists of the capacity to voluntarily block out undesirable feelings, which is important at times when the attention must be focused on something else. Suppression was related to CT closeness, indicating that when present it may influence therapists towards feelings of involvement and affinity for patients' more mature characteristics.

The last defense mechanism that exhibited significant results, was fantasy, which is an immature defense related to a patient's tendency to indulge in unproductive daydreams that distance themselves from conflicts and anxieties. The inverse relationship with CT indifference possibly indicates that therapists become involved with some patients' digressive style, reducing the presence of feelings that might result in distancing.

Other analyses, which resulted in the next findings that will be discussed, were conducted using the appropriate methods, but should be interpreted with care, because they diverge from the primary objective. The first of these findings is related to the gender of the therapists. Female therapists exhibited higher CT closeness scores than male therapists. It is already known that there are important differences in treatment process between differently composed therapist-patient dyads[38] and this finding may be useful in relation to this. The higher degree of closeness associated with female therapists may be linked to a "feminine" characteristic of psychodynamic psychotherapy, which involves obvious maternal features. Differences related to the gender of the therapist and different CT results have been reported in previous studies. For example, to demonstrate how these differences can indeed exist, a study investigating women who had been victims of trauma demonstrated that only when the therapists were women was a relationship detected between mature defenses and indifference.[39]

Other findings involve use of medications, psychiatric diagnoses and economic class. With regard to use of

medications, higher CT closeness scores were associated with patients who were not on medication. One possible explanation for this finding is that psychodynamic psychotherapists may establish a closer connection when medication is not involved, i.e., they may be able to apply their techniques with greater focus. However, the study did not analyze the types of medication involved and different categories of medications are linked with several other elements, such as the severity of patients' conditions.

Patients' socioeconomic status exhibited a significant association with CT indifference: patients from class B had lower scores than those from class C and the cluster formed from classes D and E. These results indicate that patients' socioeconomic levels affect treatment, to the extent that therapists exhibit with greater intensity feelings that could weaken the therapeutic relationship and which are included in this domain of CT. The main explanation for this finding is likely to be that patients from lower socioeconomic classes may exhibit different life experiences from the resident therapists who, while they may have faced some difficulties previously or at the time of therapy, have enjoyed good professional and academic opportunities. In comparison, a study in which therapists assessed their CT watching videos in which actors played patients from differing social classes, found that the videos of patients from less privileged economic classes resulted in predominance of a type of CT termed dominant, which describes the behavior of people who direct, control and exert influence.[40] These results are opposites, although the studies had different designs and objectives, including the fact that one is a laboratory study of CT and the other a clinical study.

Analysis of the association between CT and primary psychiatric diagnosis showed that patients with personality disorders provoked higher scores for closeness than patients with mood or anxiety disorders. If this result were to be interpreted here, it must be observed that it conflicts with the reports of previous studies that have investigated therapists' reactions to patient vignettes. These studies found that the reactions to patients with borderline personality disorders included higher intensity hostility than the reactions to patients with depression or schizophrenia.[41,42] However, while the clusters formed made analysis possible, they do not allow for more precise results. The personality disorders cluster, for example, comprised two cases, one a case of borderline personality disorder and the other a case of obsessive-compulsive personality, which, according to at least one study, provoke different CTs.[43] Another fact that weakens these findings is that the manner in which the diagnosis was arrived at negates a significant part of their validity. However, using diagnostic instruments, whether administered by the therapist or by the researchers, would have increased the costs of the research process and would have introduced one more factor influencing treatment and may not have resulted in benefits regardless.

With regard to the sample studied here, the findings observed may be of use in other settings and with different patients, but the population studied comprised resident psychiatrists, i.e. psychotherapists still in training, and patients treated by the SUS, which have different characteristics to those found, for example, in private settings. It is very much a possibility that the way that CT functions is different when therapists are older and more experienced and are providing therapy under different conditions, such as when they are being paid for the service they are providing.

This study is subject to a number of limitations, such as the sample size, which was suitable for nonparametric distribution of the majority of variables and restricted the use of analyses such as multivariate linear regression, which would have been an appropriate method for investigating interactions between the variables. This limitation may have prevented identification of more robust associations or of additional results, bearing in mind that even with nonparametric analyses significant associations were detected. As mentioned above, the diagnoses were not arrived at using a specific instrument, which reduces their precision. The enrollment process involved two elements that are possible sources of bias. The first was the use of an online questionnaire, which meant that only patients with access to the internet took part, while the second is the fact that the therapists invited patients to take part in the study, opening up the possibility that they could have given preference to inviting more collaborative patients, with whom they had better bonds. Measurement bias was introduced by the fact that assessments were not conducted at identical points in the therapy, since the sessions assessed ranged from the fourth to the tenth. The primary instrument administered was the ACTS, which to date had been used in few studies and so there is little data on its psychometric properties. The only psychometric study of the ACTS involved therapy for women who had been subject to psychological trauma, which is a different population to the one studied here. The reason for choosing the ACTS is that there are no better-known instruments that have been translated into Portuguese and adapted for the Brazilian population. Additionally, the configuration of the ACTS involves separation into positive and negative CT, which is also a feature of other instruments, but the resulting classification may be artificial. This could be considered a limitation in

view of the absence of analyses of the specific subtypes of CT that comprise the three major domains, such as rage or curiosity, and their associations with the other variables. There is no doubt that the number of significant results would have been high, the majority due to chance and over-analysis. There are similar reasons for not conducting analyses of relationships between variables that are unrelated to CT.

There is a vast body of theoretical literature on CT and very few clinical studies.[9] The existence of review studies and meta-analyses of the subject suggests that CT is gradually finding its way on to the psychotherapy research agenda.[21,44-47] Future studies could investigate the elements of CT that are exclusive to the therapists, known as subjective CT, and the elements that are provoked by characteristics specific to the patient, known as objective CT,[48] with the aim of better explaining how each contributes to CT. There are other important concepts that are related to CT and which could be studied in future research, such as, for example, enactment, projective identification, therapists' somatic changes (such as somnolence), CT linked with vicarious traumatization (provoked by treating patients with high levels of stress) and how unconscious elements of the therapist and patient interact. Beyond quantitative studies, qualitative research investigating the process of psychotherapy could also advance knowledge about CT and its relationship with the analytic or psychotherapeutic field formed by patient and therapist. Another important aspect to be taken into consideration is related to conducting longitudinal studies, which make it possible to evaluate the patterns of development of the features under observation. Studies of the psychometric properties of the instruments are also needed, especially studies to validate those that are most used with the local population, which would enable future studies to be more robust.

Countertransference is one of the most important theoretical and technical elements within psychodynamic psychotherapy, providing a series of items of information that are invaluable to well-conducted clinical practice and to good results. The presence of feelings with negative qualities, that cause therapists discomfort, may indicate problems with the TA, which, in turn, has a well-established role in psychotherapy. Additionally, it is linked with characteristics of the patients themselves, such as defense mechanisms or socioeconomic level.

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